



Disabled Pass Application

The information in this application will only be used by TRANSFORT to determine eligibility for a DISABLED PASS.

According to the Americans with Disabilities Act of 1990, a disability means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment.

Please complete the following information and authorization form:

Name: _____
Address: _____
City/State/Zip: _____
Telephone (home): _____ (work) _____

In order to allow TRANSFORT to evaluate your request, it is necessary for you to contact a physician or other healthcare professional to complete the following verification. *A valid Medicare card may be substituted for a doctor's signature.

PROFESSIONAL MEDICAL VERIFICATION

Name of Healthcare Professional: _____
Address: _____
Telephone: _____

The above named individual is under my care. This person meets the definition of disabled as indicated above: (CHECK ONE)

YES _____ **NO** _____

This disability is: (CHECK ONE)

PERMANENT _____ **TEMPORARY** _____

Other comments: _____

Signature (Stamped signatures are not acceptable)

Date

Form may be returned by mail to Transfort, 6570 Portner Road, Fort Collins, CO 80525, or via Fax 970-221-6285.

For Office Use Only: Medicare Card # _____ Pass serial number _____ Verified By: _____ Date received: _____
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